

Application for Dental Provisional Licensure by Credentials

Attached is the application for a Georgia dental provisional license by credentials. **Please read all supporting documents below before completing the attached application.**

NOTE: All fees are non-refundable and non-transferable. The licensure process could take up to a minimum of **30 days** after submission of a completed application. Plan your application time accordingly.

All questions on the application must be answered.

ATTENTION: ALL SUPPORTING DOCUMENTS MUST BE MAILED WITH COMPLETED APPLICATION IN ONE PACKAGE TO THE BOARD OFFICE.

O.C.G.A § 43-11-41 and Board Rule 150-7-.04 give the specific requirements for provisional licensure by credentials. These laws and rules may be found on the board's website at www.sos.state.ga.us/plb/dentistry.

In order to verify your compliance with licensure requirements submit:

1. **Completed application form** accompanied by a fee of **\$3,000.00** (subject to change). Your application will not be processed unless the fee and all supporting documents are received. This is only an application fee. If licensure is granted, the license will be required to be renewed by the last day of December in ODD numbered years, regardless of when you were originally licensed. Personal checks or money orders are acceptable, payable to the order of **Georgia Board of Dentistry. APPLICATION FEES ARE NON-REFUNDABLE AND NON-TRANSFERABLE.** Checks returned for insufficient funds will be assessed a \$30 service charge pursuant to O.C.G.A. § 16-9-20.
2. **Incomplete applications** are maintained in the Board office for a period of two (2) years. After such time the application is rendered **void** and the applicant **must** re-apply and pay all required fees. **All fees are non-refundable and non-transferable.**
3. **Official letter(s) of licensure verification** for **every** dental license **ever** held. Each letter must indicate the date of licensure, the licensure status (active, inactive, expired, revoked, etc.) standing of license, any disciplinary charges made against you by the licensing board or by any other state agency, and the result of these actions. The applicant must provide a copy of the formal complaint/pleading, outcomes, and a personal written explanation for each instance of discipline. You should call each state board about fees for these services. **The letter(s) must be submitted with your application IN THE ORIGINAL SEALED ENVELOPE FROM THE BOARD OF EACH LICENSING STATE,** and must be dated within four months of Board receipt of your complete application packet.

4. **An Official Transcript** which documents graduation with a D.D.S. or D.M.D. degree from a dental school which is accredited by the American Dental Association Commission on Dental Education. **The transcript must be IN THE ORIGINAL SEALED ENVELOPE FROM THE COLLEGE. Graduates from a non-accredited school please see Rule 150-3.04 and O.C.G.A. § 43-11-40(a)(1)(A) and (B).**
5. **National Board Scores** from the ADA Joint Commission on National Dental examinations. The ADA (1-800-621-8099) will send a copy of National Board scores to state licensure boards only. If you ask the ADA to send our board a copy of your National Board scores, so indicate in your application packet. **DO NOT SUBMIT THE NATIONAL BOARD CERTIFICATE. NATIONAL SCORES MUST COME DIRECTLY FROM THE NATIONAL BOARD TO OUR OFFICE. All candidates must have taken and passed a clinical examination with a score of 75 or greater on all sections of the examination. The clinical examination MUST be Board approved.**
6. **Verification that the applicant has successfully completed** with a passing score in each section, a clinical licensing examination in general dentistry conducted by a regional or state testing agency that meets the following criteria:
 - a. Anonymity between candidate and examiners.
 - b. Psychometrically valid procedures for standardization and calibration of the examiners.
 - c. A post examination analysis of the scoring for single examination aberrations.

Such verification shall state that the examination included clinical testing on live patients in the following areas:

- a. Periodontal clinical abilities testing.
- b. Completion of at least two of the following four areas:
 - a. Class II Amalgam preparation and finish
 - b. Cast Gold preparation and finish, Class II inlay, onlay, partial or full coverage crown
 - c. Class II Composite preparation and finish
 - d. Class III Composite preparation and finish

Such verification shall also include clinical testing on mannequin or model in the following areas:

- a. Endodontic clinical abilities testing access opening and root canal fill
- b. Prosthodontic clinical abilities testing of partial denture, full denture and implant case planning.

Additional clinical abilities testing modules successfully completed will be considered as substitutes where appropriate for the above requirements if those modules test a similar skill set. **If the examination completed did not require testing in the above listed modules, the application will need to be considered on an individual basis.**

7. **Jurisprudence Examination.** The examination must be downloaded from our website (see-applications and other forms) The study materials are also on our website. (www.sos.state.ga.us/plb/dentistry) The fee for this examination is \$25.00, payable to the order of **Georgia Board of Dentistry. FEES ARE NON REFUNDABLE.** *A score of 75 or higher is considered a passing score.*
8. **A National Practitioner Data Bank (NPDB)** certified report of any pending or final disciplinary actions or malpractice actions against any license ever held by the applicant in any state. **All applicants must submit a NPDB report along with a completed application.** (NPDB must be dated within four months). The NPDB report **must** be received in the **ORIGINAL SEALED ENVELOPE FROM NPDB.** Those applications which have any disciplinary or malpractice case(s) (open & closed) will be considered for licensure on a case by case basis, after receipt of all required application materials. For each case, the applicant must submit: 1) a copy of the formal complaint pleadings filed by the plaintiff/complainant or State Regulatory Agency, 2) a copy of the final action, disposition, or settlement, 3) a personal explanation of the disciplinary action or the malpractice claim, and 4) any further information requested by the Board in separate communications. To obtain information (self-query) from the NPDB-HIPDB, please visit www.npdb-hipdb.com, scroll to the right side of the home page, and click **Perform a Self-Query.** The self-query is \$20.00, payable by credit card (VISA, MasterCard, Discover, or American Express). If you do not have Internet access, contact the Customer Service Center at 1-800-767-6732 from 8:30 a.m. to 6:00 p.m. Eastern Time (8:30 a.m. to 5:30 p.m. Fridays).
9. **Copy of Court Document or Affidavit** explaining any discrepancies of the applicant's name if documents submitted bear different name(s).[i.e. marriage certificate, divorce decree, legal name change]
10. A photocopy of current CPR certification in compliance with Board Rule 150-3-.08.
11. **Verification of applicant's registration** with the federal Drug Enforcement Administration (DEA), from the DEA, even if applicant is not currently registered with the DEA.
12. **An affidavit from the applicant stating for the five years** immediately preceding application: (A) the dates and locations where the applicant has

practiced dentistry; and (B) that the applicant has been in full time clinical practice of a minimum of 1000 hours per year in the hands on treatment of patients. Training programs do not qualify as full time clinical practice.

13. **Malpractice Questionnaire** - Be sure to complete one for each suit and attach the necessary documentation. (If not applicable, write N/A on the form sign, date, and return with application).
14. **ALL dental provisional licenses by credential applications MUST BE APPROVED by the Board.**
15. **Upon receipt of the license, the applicant by credentials must establish active practice in this state within two years of receiving such license or the license shall be automatically revoked.**

Relocation: If you relocate during the time that your application is being processed, you **must** notify the Board of your new address in writing by fax (478) 207-1699 or mail. This will enable you to receive Board correspondence.

SUBMIT YOUR COMPLETED APPLICATION PACKET TO

**Georgia Board of Dentistry
237 Coliseum Drive
Macon, Georgia 31217**

**Listing of States accepted for
Provisional Licensure by Credentials
Dental and Dental Hygiene**

Alabama
Alaska
Arkansas
Arizona
California
Colorado
Connecticut
Delaware
Idaho
Illinois
Indiana
Iowa
Kansas
Kentucky
Louisiana
Maine
Maryland
Massachusetts
Minnesota
Mississippi
Missouri
Montana
Nevada
New Hampshire
**New York
North Carolina
North Dakota
Ohio
Oklahoma
Oregon
Pennsylvania
*Puerto Rico
Rhode Island
South Dakota
Tennessee
Texas
Utah
Vermont
Virgin Islands
Washington
West Virginia
Wisconsin

*Information Pending

**Yes, provided completion of a clinical
licensing examination and not PGY1.

**States not accepted for Provisional
Licensure by Credentials – Dental and
Dental Hygiene*****

District of Columbia
Florida
Hawaii
Michigan
Montana
Nebraska
New Jersey
New Mexico
South Carolina
Virginia
Wyoming

***Please note that the states listed as not
approved do not have substantially
equivalent laws for licensure / licensure by
credentials as Georgia. Therefore, the board
is prohibited from considering applicants for
licensure by credentials for individuals who
have these states as their initial state of
licensure.

Please note all application fees are non-
refundable and non-transferable.

This list is subject to change and will be
updated on an as needed basis.

Updated 07/06/05

**Do Not Write In This Section:**

Receipt#: _____
Amount: _____
Applicant #: _____
Initials/Date: _____

Board Name: Georgia Board of Dentistry
Address: 237 Coliseum Drive
Address: Macon, GA 31217-3858
Telephone #: (478) 207-1686
Fax #: (478) 207-1699
Website: www.sos.state.ga.us/plb/dentistry

Application For: Dental Provisional License by Credentials

Obtained By Method – Credentials - \$3,000 Non-refundable/Non-transferable application fee.

Checks returned for non-sufficient funds will be assessed a \$30 service charge pursuant to O.C.G.A. § 16-9-20

DISABILITY- If you have a disability and may require an accommodation, you must contact the Board to obtain the REQUEST FOR DISABILITY ACCOMMODATIONS GUIDELINES.

VETERANS PREFERENCE POINTS- Veterans may be eligible for special benefits in testing. For more information, contact the Board office. **Submit copy of DD-214 with your application.**

Part I: Personal Information

1. Name: _____
Last First Middle Maiden

2. Mailing Address: _____
(Street) (Apt. #) (City/State/Zip Code)

3. If your mailing address is a P.O. Box, you must provide a physical address:

(Street) (Apt. #) (City/State/Zip Code)

If you are granted a license, your name, mailing address and license number are public information.

4. E-Mail Address: _____

5. Telephone #: Home: () _____ Work () _____ Other () _____

6. Date of Birth: _____ 7. Gender: ____M ____F

8. Race: _____ 9. Ethnicity: ____ (Hispanic or Latino) ____ (Not Hispanic or Latino)

10. Social Security Number*: _____ - _____ - _____

11. Military Service: _____ Dates of Service: _____
Honorable/Dishonorable Discharge: _____

*This information is authorized to be obtained and disclosed to state and federal agencies pursuant to O.C.G.A. §19-11-1 and O.C.G.A. §20-3-295, 42 U.S.C.A. §551 and 20 U.S.C.A. §1001. It may also be disclosed to the National Practitioner's Databank (NPDB) and the Healthcare Integrity and Protection Data Bank (HIPDB) or other licensing boards, or other regulatory agencies for license tracking purposes.

Part II: Professional Education

12. Highest Degree Earned: ____ Doctorate ____ Post-doctorate

13. Name/Address of undergraduate college/university: _____

- a. Dates Attended: _____ c. Graduation Date: _____
b. Major: _____ d. Degree(s) Earned: _____

14. Name/Address of Dental School/University: _____

- a. Dates Attended: _____ c. Graduation Date: _____
b. Major: _____ d. Degree(s) Earned: _____

15. Name/Address of Post-Graduate School/Hospital
(if applicable): _____

- a. Type of Training: _____ b. Dates Attended: _____

16. National Board Information:

I understand that it is my responsibility to see that a copy of my scores be mailed from the Joint

Commission on National Dental Examinations directly to the Board. For your convenience, the number is: 1-800-621-8099.

Signature of Applicant

17. National Practitioners Data Bank/Healthcare Integrity and Protection Data Bank

The Georgia Board of Dentistry requires all candidates for licensure to query the NPDB/HIPDB before licensure will be granted: You may contact the NPDB/HIPDB by calling: 1-800-767-6732 or by submitting your query online at: www.NPDB.com. (When you receive the RESPONSE from the NPDB/HIPDB please forward the information to the Board office along with your completed application). **If you are a recent graduate (within the past six months) and not licensed in any other state, you are exempt from this requirement.**

Part III:

If yes to any of the following questions you must attach a full written explanation pertaining to that particular question.

18. Was your pre-dental education or dental education interrupted, other than the usual vacation periods?

☐ Yes ☐ No

19. Do you presently have any contagious or infectious disease? ☐ Yes ☐ No

20. Have you ever been charged with driving under the influence of alcohol or drugs? ☐ Yes ☐ No

21. Have you ever had a formal complaint filed against you with any dental society, association, hospital, or dental board? ☐ Yes ☐ No

22. Has any state licensing board revoked or suspended your certificate/license, or taken other disciplinary action? ☐ Yes ☐ No

23. Have you ever been denied a DEA registration number or been issued a restricted DEA registration?

☐ Yes ☐ No

24. Have you ever voluntarily surrendered a dental license, a controlled substances registration, or DEA registration? ☐ Yes ☐ No

25. Have you ever had any malpractice suits filed against you? ☐ Yes ☐ No

26. Have you ever been denied participation in, or suspended from the Medicaid or Medicare benefit program? ☐ Yes ☐ No

27. Have you ever been denied issuance of or, pursuant to disciplinary proceedings, refused renewal of a license by any board or agency in Georgia or any other state? ☐ Yes ☐ No
28. Have you ever been denied the privilege of taking an examination before any Dental Board or licensing authority? ☐ Yes ☐ No
29. Have you ever failed an examination required of any Dental Board or other licensing authority? ☐ Yes ☐ No
30. Have you failed any portion of a Regional Board Examination(s) or any other State examination in the past five (5) years? ☐ Yes ☐ No **If yes, give dates (list regional or state if applicable)**

31. Have you ever been refused any privilege of prescribing controlled substances, or had any prescribing privileges of controlled suspended or revoked? ☐ Yes ☐ No

32. Have you ever been refused, or suspended from membership in a dental society, or association, or hospital staff? ☐ Yes ☐ No

33. Have you ever personally used narcotics or alcohol excessively or have you ever undergone treatment for addiction to alcohol or other controlled substances or habit forming substances? ☐ Yes ☐ No

34. Have you ever been summoned, arrested, taken into custody, indicted, convicted or tried for, or charged with, or pled guilty to, or pled, nolo contendere to, a violation of any law or ordinance or the commission of any felony or misdemeanor (excluding minor traffic violations), (DWI & DUI are **not** minor traffic violations), or have you been requested to appear before a prosecuting attorney or investigative agency in any matter? ☐ Yes ☐ No

(Although a conviction may have been expunged from the records by order of court, it nevertheless must be disclosed in your answer to this question). If yes, for **each** occurrence furnish a written statement giving the complete facts in your own words, including in such statement the date, name and nature of the offense, the name and locality of the court, and the disposition of each such matter. **You must attach the court disposition.**

35. Are there any other facts not disclosed by your answers which may have a bearing on your fitness or eligibility to practice dentistry in Georgia and which should be placed at the disposal or brought to the attention of the State Board of Dentistry? ☐ Yes ☐ No

36. Out of State Licensure Certification(s):

List all states which you have been issued a license to practice dentistry: (active, inactive, revoked, suspended, expired, lapsed etc.) You should have each state listed send an official letter of licensure verification/certification. **See instruction sheet for details.**

<u>STATE</u>	<u>DATE OF LICENSURE</u>	<u>LICENSE STATUS</u>
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

37. References: Listed below are two references whom I have supplied with the proper form that was included in my application packet.

I understand that it is my responsibility to see that these forms are returned. I certify these references are not related to me, nor are they connected with any dental college I attended.

Name_____

Name_____

Address_____

Address_____

City, State, Zip_____

City, State, Zip_____

Occupation_____

Occupation_____

Part IV:

38. AFFIDAVIT OF APPLICATION

I acknowledge and state that I have read the Application and Instructions that accompanied this application and I have answered all questions in compliance with these instructions. I acknowledge that it is my responsibility to read and become familiar with the Dental Practice Act and the Board Rules.

I further state that by submitting this application for a license to practice dentistry/dental hygiene in the State of Georgia, I hereby authorize and consent to have an investigation made as to the moral character, professional reputation and fitness for the practice of dentistry/ dental hygiene. I agree to give any further information in which may be required in reference to my past record. I understand that I will not receive a copy of the report or know its contents and I further understand that the contents of the investigative report will be privileged unless determined otherwise by the Board of Court Order.

I hereby authorize the Georgia Board of Dentistry to receive any criminal history record pertaining to me, which may be in the files of any state or local criminal justice agency in Georgia or any other State or Territory.

I authorize and request every person, hospital, clinic, community, governmental agency (local, state, federal or foreign), court, association, institution, or other organization having control of any documents, records and other information pertaining to me, to furnish to the Georgia Board of Dentistry any information, including documents, records, regarding charges or complaints filed against me, formal or informal, pending or closed, or any other pertinent data and to permit the Georgia Board of Dentistry or any of its agents or representatives to inspect and make copies of such documents, records and other information, in connection with this application, subsequent licensure or practice thereunder.

I hereby release, discharge and exonerate the Georgia Board of Dentistry, it's agents or representatives, and any person so furnishing information, from any and all liability of every nature and kind arising out of the furnishing or inspection of such documents, records or other information or the investigation made by the Georgia Board of Dentistry. I authorize the Georgia Board of Dentistry to release information, material, documents, orders or the like relating to me or to this application to any other State or Territory of the United States or Province of Canada, a law enforcement agency, a hospital or other appropriate agencies as determined by the Board.

This is to certify that the foregoing information is true and correct to the best of my knowledge.

Signature of Applicant

Date _____

(Print Name Above)

County _____ State _____

being duly sworn, says that he/she is the person who executed the above application for license to practice dentistry/dental hygiene in the State of Georgia; and that all the statements herein contained are true in every respect and that the attached photo is a true photo of the applicant.

(PHOTOGRAPH)
Please attach recent photograph

Notary Public

Sworn to and subscribed before me this _____ day of _____, _____.

(SEAL) My Commission Expires _____

Notary: Do not notarize this section unless photograph is attached.

Part V: MALPRACTICE QUESTIONNAIRE

Name of Dentist

Business Telephone

Address

City, State, ZIP

MALPRACTICE CHARGES/ALLEGATIONS: Include name of patient, age, sex, date of occurrence and location (include address).

List names of other dentist and/or physicians: _____

DISPOSITION: ☐ Pending ☐ Settled If settled, provide the following information:

Settlement Date_____ Total Settlement Amount_____

Amount Attributable to you: _____ ☐ In Court ☐ Out of Court

The Board requires that you furnish documentation of the above information directly from the insurance company or attorney to the above address. Such documentation should include plaintiff's complaint, settlement agreement, and/or court order.

Signature

Date

COMPLETE ONE QUESTIONNAIRE ON EACH MALPRACTICE SUIT
YOU MAY DUPLICATE THIS FORM.

If not, applicable, please write (N/A), sign and return with completed application.

Part VI: STATE LICENSURE CERTIFICATION

TO THE APPLICANT: *Please complete the top section of this form and mail to each state in which you are now or have been licensed to practice dentistry. This form may be reproduced as necessary.*

TO: _____ **Board of Dentistry**

I am applying for licensure and the Georgia Board requires that your Board complete this form in order that my application for licensure may be considered. By signing this form, I am giving my consent to the release of any information, favorable or otherwise, for its review in considering me for licensure.

My license Number _____ was issued by your Board on _____ on the basis of () State Board Exam, () Reciprocity/Endorsement, () National Board, () Credentials, () other _____.

Applicant's Full Name (print or type)	Address
Signature	City State ZIP

This section to be completed by an official of the above referenced licensing board. Please return this form directly to the applicant in a sealed envelope.

Dental License Number _____ to practice dentistry in the State of _____ was issued on _____ to _____ Licensee

Is license current and in good standing? ____ Yes ____ No*

Has any disciplinary action ever been taken against this license?

____ Yes* ____ No , ***If yes, please attach disciplinary documents.**

**** Please provide complete details, including copies of any documents.***

Signature	Date
Title	(BOARD SEAL)
Licensing Board	

Part VII**GEORGIA BOARD OF DENTISTRY****AFFIDAVIT****DENTAL PROVISIONAL LICENSURE BY CREDENTIALS**

This form must be completed, signed, notarized and returned with the application packet.

For the five years immediately preceding my application for licensure by credentials, I have practiced at the following locations:

Location	Dates of Employment

I have been in full time clinical practice of a minimum of 1,000 hours per year in the hands-on treatment of patients . I understand that training programs do not qualify as full time clinical practice.

Signature

Date

Affirmed to and subscribed before me this _____ day of _____, 20_____.

(Official Seal)

Notary Public

My commission expires _____, 20_____.

GEORGIA BOARD OF DENTISTRY

237 Coliseum Drive
Macon, Georgia 31217-3858
(478) 207-1686

Rev. 6/6/2005

(You may duplicate this form)

TO THE REFERENCE: The person listed below is applying for licensure as a dentist in the State of Georgia. The applicant is required to furnish satisfactory evidence that he/she is qualified to practice professional dentistry. You have been given this form as one who knows the applicant well and can attest to his/her character, ability, reputation, and professional attainments.

The statements you provide must be from personal knowledge only, and should be made with full realization of the responsibility toward the public involved. You should answer fully, carefully, and with the utmost frankness.

Be assured that the information you furnish will be treated as **strictly confidential**. Please return your recommendation directly to the applicant. **RETURN TO APPLICANT IN A SEALED ENVELOPE.**

NAME OF APPLICANT _____

FROM _____
Reference Full Name (Daytime telephone # including area code)

Address

City Zip Code

1. Are you a licensed dentist? ____ **Yes** ____ **No** If yes, what state(s)? _____

If no, what is your present profession? _____

2. How long have you known the applicant? ____ Years. Are you related? _____

3. In what capacity have you known him/her _____

4. Do you know anything reflecting adversely on the applicant's integrity or general good character?
____ **Yes** ____ **No** If yes, give details on a separate page.

5. Do you feel that this applicant is qualified to have responsibility of a dental office? ____ **Yes**
____ **No** If no, give details on a separate page.

6. Would you feel comfortable going to this person for your dental needs? ____ **Yes** ____ **No**
If no, give details on a separate page.

7. What is the applicant's character, reputation, and standing in the community?

page 2 Reference Form continued

NAME OF APPLICANT _____

FROM _____

Additional Comments _____

The undersigned certifies that the above statements, to the best of his/her knowledge and belief, are correct.

Signature

Title

Date